Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 22, 2022	2022_747725_0007	017446-21, 018183-21, 018448-21, 018797-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Tecumseh
2475 St. Alphonse Street Tecumseh ON N8N 2X2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CASSANDRA TAYLOR (725)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 9-11 and 15-18, 2022.

The following complaint intakes were inspected during this inspection;

Log: # 017446-21 - relating to allegations of neglect of care.
Log: # 018183-21 - relating to allegations of chemical restraint for responsive behaviours.
Log: # 018183-21 - relating to care concerns of; post fall assessments, nutrition and hydration and infection control.
Log: # 018797-21 - care concerns relating to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Assistant Director of Care, one Registered Nurse, three Registered Practical Nurses, four Personal Support Workers, one Registered Physiotherapist, one Registered Dietitian, one Dietary Manager, one Dietary Aide, one Manager of Environmental Services and one Housekeeping staff member.

During the course of this inspection the inspector(s) also spoke with residents and completed observations and record reviews relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for the resident was based on an assessment of the residents needs.

The resident sustained an injury requiring an increase in the level of care from their previous care requirements. The care plan was not updated to support the required level of care until a specific date after their injury.

The review of the provisions of care provided indicated that the resident was receiving increased levels of care at times.

During interviews, the Personal Support Worker (PSW) indicated that they would look at the residents care plan for directions on care. The Registered Practical Nurse (RPN) indicated that care changes should be updated immediately in the care plan. An interview with the Director of Care (DOC) indicated that the care plan for the resident should have been updated at the time of the change.

Not ensuring the care set out in the plan of care was based on the residents need placed the resident at potential risk for missed care opportunities.

Sources: Resident records and staff interviews with PSW , RPN and the DOC. [s. 6. (2)]

2. The Licensee has failed to ensure that the provisions of care set out in the plan of care for the resident were documented.

The resident required medications to be administered at a specific interval during a specific time frame. Review of the Electronic Medication Administration Record (E-MAR) indicated that no dose was documented as given on two specific occasions.

The DOC indicated that it would be the expectation that staff document the administration in the E-MAR or document an exception if not given.

Not documenting the medication administration placed resident #001 at a potential risk for a medication error.

Sources: Resident records, E-MAR and DOC interview. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care for the resident is based on an assessment of the residents needs and that provisions of care are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

O.Reg. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

A resident was documented as having sustained an injury and had altered skin integrity on a specific date. The resident had left the home and returned to the home at a later date and no head-to-toe assessments were completed until after a specific date.

An assessment was completed by the Physiotherapist (PT) on a specific date, indicating altered skin integrity and no head-to-toe assessment was completed. The same resident

had left the home and returned to the home again on a specific date, upon return a head-to-toe skin assessment was completed and noted the altered skin integrity. Another PT assessment was completed on a specific date, which again noted the altered skin integrity. No follow up head-to-toe assessment was completed seven days after the initial assessment.

The homes policy titled Skin and Wound Program Prevention of Skin Breakdown; indicated under the procedure section, “Preform a comprehensive head-to-toe skin assessment for all residents; B. for a specific situation. Also from the Wound Care Management it stated in part, “"A resident exhibiting any form of altered skin integrity, which many include but is not limited to skin breakdown, unexplained bruises, pressure injuries, skin tears and wounds, will:
- received a skin assessment by a Nurse using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments; and
...- be reassessed at least weekly by a Nurse, if clinically indicated.”

During a staff interview with the RPN they indicated residents returning with injuries should have a head-to-toe skin assessment completed and altered skin integrity should be monitored weekly using the head-to-toe skin assessment. When asked, the DOC indicated that the assessments should have been completed and it would be the expectation that staff follow the policy and completed the head-to-toe skin assessments when required.

Not completing head-to-toe skin assessments when required placed the resident at potential risk for undetected altered skin integrity issues.

Sources: Resident records, Skin and Wound Program policies, staff interview with RPN and DOC. [s. 8. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were monitored in the dining room during meal service.

On a specific day, a specific unit was observed to have residents eating in the dining room unsupervised. There was a specific number residents in the dining room towards the end of meal service, some of which were still eating or had plates of food in front of them. The inspector waved the RPN down and they came to the dining room. When asked, the RPN indicated that residents in the dining room should be supervised, and that the staff were likely taking residents back to their rooms as it was the end of meal service. The RPN indicated that they would monitor the remaining residents in the dining room. Shortly after the RPN attended the dining room, a resident attempted to get up and they were unsteady. The RPN assisted the resident with their walker. Roughly after five minutes of the discovery of the unsupervised dining room a PSW attended the dining room. When asked the PSW indicated that residents in the dining room should be supervised.

The inspector also observed the another specific unit on the same day, at the end of meal service and found residents in the dining room unsupervised, three of which were actively eating. The Registered Nurse (RN) was across the hall. The RN attended the dining room at the request of the inspector and when asked, the RN indicated that the residents should be supervised as the population is at risk for choking and that they would monitor the remaining residents.

Both the Administrator and DOC indicated that the home’s policy is that the residents are monitored while in the dining room for meal service.

Sources; Observation, staff interviews with PSW, RPN, RN and the Administrator and DOC. [s. 73. (1) 4.]

2. The licensee has failed to ensure that the resident was assisted with drinking in a safe position.

On a specific date, inspector observed a PSW assisting a resident with a drink. The resident was not in the upright seated position. When asked the PSW indicated that the resident was in that specific position as an intervention. Review of the resident's care plan did not have the specific position for eating or drinking as an intervention. Both the Registered Dietitian (RD) and the DOC indicated that the resident should have been in an upright position when being assisted to drink.

Not ensuring safe positioning while assisting the resident to drink placed the resident at risk for potential choking.

Sources: Observation, Staff interviews with PSW, RD and DOC. [s. 73. (1) 10.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not administered a drug, unless that drug was prescribed to them.

The resident was identified as having had a medication on a specific date. An error was made on a later specific date where the registered staff member, administered a similar medication of a different dose. The DOC confirmed the resident was monitored and the medication incident procedure was followed, without ill effect.

Administering a medication to the resident that was not prescribed posed a potential risk for an adverse medication reaction.

Sources: Medication incident and DOC interview. [s. 131. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's symptoms of infection were monitored on every shift.

The resident was diagnosed with an infection on a specific date. The resident was prescribed a medication to be administered for a specific time frame. There was no infection monitoring documented for seven shifts of specific dates and times.

The DOC indicated that symptoms of infection should be monitored each shift and documented.

Not monitoring symptoms of infection on every shift placed the resident at potential risk for undetected symptom changes.

Sources: Resident records and interview with the DOC. [s. 229. (5) (a)]

Issued on this 28th day of March, 2022

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.